# COMMISSION ON MENTAL HEALTH AND DEVELOPMENTAL SERVICES FRIDAY, DECEMBER 7, 2001

MEETING LOCATION: DRC

### PHONE ACCESS AVAILABLE AT SRC

#### MINUTES

#### COMMISSIONERS

PRESENT: Frances Brown, MSN, MSEd. RN, Chair

David Ward, Vice Chair

Eric Albers, Ph.D. John Brailsford, Ph.D. Elizabeth Richitt, Ph.D.

Rena Nora, M.D. Johanna Fricke, M.D.

#### **CALL TO ORDER**

Chair Fran Brown called the meeting to order.

#### APPROVAL OF MINUTES

**MOTION:** Dr. Rena Nora made a motion to approve the 11/1/01 meeting minutes with recommendations. Dr. Elizabeth Richitt seconded. Motion carried.

**MOTION:** Dr. Nora made a motion to approve the 11/2/01 meeting minutes with recommendations. Dr. Richitt seconded. Motion carried.

#### INTRODUCTION

Ms. Brown introduced Dr. Johanna Fricke, newest member of the Commission. Dr. Fricke reviewed her experience and expressed her pleasure in being appointed.

#### **HIV/AIDS ANNUAL SURVEILLANCE REPORT 2000**

Mr. Richard Whitley, Chief, Bureau of Health stated that in 2000, reported HIV infections in Nevada increased for the first time since 1996. Between 1999 and 2000, reported HIV rates increased in both men and women. Race and ethnicity data showed increased rates in White, Black and Hispanic men and women.

The majority of HIV cases reported in 2000 were acquired through sexual transmission. Exposure category analyses for 2000 showed that men who have sex with men (MSM) accounted for 54.9% of all Nevada HIV cases and 65.7% of male cases. The greatest increase in reported HIV cases between 1999 and 2000 were in men who have sex with men and within this exposure category, men in the 30-39 year old age group were most affected.

Targeted prevention efforts toward communities with disproportionately higher HIV rates must be enhanced to stop the increase in morbidity observed in year 2000.

Mr. Whitley gave a brief summary of some of the findings from an effort to look at the number of persons with HIV who also appeared in the Southern Nevada Adult Mental Health Services (SNAMHS) Database (as of May 2001). The database used for determining persons with

HIV/AIDS is called HARS or the HIV/AIDS Reporting System. Cross matching these two databases made it possible to determine the number of persons with HIV and/or AIDS who also suffer from some type of mental illness. Persons who are mentally ill in Southern Nevada are almost 3½ times more likely to have HIV, compared to the general population. Of the persons found to be in both HARS and SNAMHS databases, 77.0% were male and 22.0% were female.

Following the same trend as Nevada's population, reported HIV infection among persons in Southern Nevada Mental Health Services increased in 2000 for the first time since 1996. The age at which the patients were diagnosed with HIV was mainly in the range of 30 to 39 years old.

The major risk category was Men Having Sex with Men (MSM), (40.6%). Injecting Drug Users (IDU) represented the second largest risk category at 26.2%. Men who had sex with men and who also were injecting drug users represented the third largest group at 16.3%. Over half of those with HIV (55.5%) were diagnosed with AIDS, indicating complications and opportunistic infections. Nearly 30% were not using antiretroviral drug therapies to deal with HIV.

The number of patients who were labeled by the attending physician as "severely mentally ill" was 45.8%. The primary admission problem indicated most was "depression", at 39.4%. "Thought disorder" was next at 15.3%, followed by suicide attempt or threat at 14%. Fifty-seven patients were admitted for a suicide attempt or threat (14.1%).

#### A few issues that stand out:

- Slightly more than 50% of the persons in the Southern Nevada Adult Mental Health Services database entered the mental health system <u>after</u> receiving a diagnosis of HIV.
- Slightly less than 50% were already in the mental health system when diagnosed.
- This preliminary data analysis just begins to tell the story of the impact of HIV/AIDS on mentally ill persons in Nevada. It begins to establish priorities for both prevention and treatment strategies.
- What is needed is to broaden the Mental Health and Public Health agendas, and to be inclusive of one another. By using data and reports, we can formally make the case to braid the systems together that serve at-risk populations.
- Cumulative factors usually result in poor health--unless we begin to look at these factors in total, we cannot effectively identify strategies for prevention.
- HIV is only one issue—other areas include STD's and TB, as well as chronic disease, such as Diabetes and Breast and Cervical Cancer.

Dr. Carlos Brandenburg stated that the percentage of MHDS clients who are HIV positive surprised the Division. Mr. Whitley reported that they don't look horizontally at the two databases. HIV is just one spoke of the mental health hub to tell us what is happening. The number of patients who are labeled as mental health clients is 45%, depression at 39%, thought disorder at 15%. There are 14% admitted due to suicide attempt or threat. 45% of Southern Nevada's mental health system were already in the system when they became HIV infected. Of those who were already positive, we wondered if they were entering the system due to HIV/Aids. As a result of no treatment, did they follow the path of substance abuse? Of

those with HIV, do they use existing resources to pay for them? Many questions need answers; Where did the system failure occur? If people are already in the system, where could interventions occur? What was occurring when these folks were infected? We need a two-prong approach for treatment and prevention.

Dr. Johanna Fricke inquired about those who were in the system. She asked whether or not they had been tested before they entered the system?

Mr. Whitley stated that it was worthy of looking into. He reported that it does tell a story of what is happening. Historically, it was a story of men having sex with men or intravenous drug users. He reported his mission is to do something with all the data that is being collected. There is a large cost savings in preventing HIV. The data really puts a map out there where interventions can occur. He stated he was looking forward to presenting a more formal report to the Commission in the near future. He also stated he was looking forward to working with Dr. Brandenburg and MHDS to enhance his existing annual report to include this data.

Dr. Rena Nora emphasized early detection. Long before lab reports, a patient comes in for depression. We should run tests, rather than just prescribe antidepressants. She further reported that the HIV/AIDS report last year stated that HIV/AIDS was rampant in seniors, but this new data shows that is not the case.

Dr. Elizabeth Richitt wondered why there was decreased testing of those at highest risk. Mr. Whitley stated that they targeted testing in terms of resources. We were testing people who were not positive, but not necessarily doing outreach to those communities that were at risk. There is fewer tests being done now, but more targeted to those at risk.

Dr. Richitt also noted the overlap between mental health and HIV and reported an article in the paper today regarding people who are served by the DS side. She asked if we have looked at any overlap there. Mr. Whitley stated they had just begun. As this unfolds, and at the Commission's request, he stated he would be happy to present that data as well.

Dr. Brandenburg felt that was an excellent point and prompted us to look at this issue. We are looking at mental health as a public health issue, rather than a medical issue. We are now looking at public information and training. We would like to see if there is a way to look at our database along with the health mortality database.

**ACTION**: Dr. Brandenburg will distribute the mortality report at the next Commission meeting.

Dr. Brandenburg further reported that the next step would include the north and rural areas, followed by the DS side. He reported that no other state was linking databases. We are in partnership with the public health nurses in rural areas linking mental health and the Division of Health. We have received funds for a Social Worker to work with the HIV community so we can share resources, information and data. Mr. Whitley stated the key was in data sharing. We are working toward more system-based data to provide information for agencies to utilize the information.

Dr. Fricke asked if children in adopted families and/or foster care could be included. She stated that she understood that with three different systems, it may be hard, but asked if they could please be tested.

Ms. Rosetta Johnson stated the problem remains with mental health clients not getting treatment if there is no force behind the resources. She referred to the laws that allow folks to stay very, very sick and crazy until they die.

Mr. Whitley stated that for public health, there are people who are incarcerated for knowingly infecting others with HIV/AIDS virus or being secluded if they have TB.

#### **NEVADA COUNCIL ON PROBLEM GAMBLING**

Ms. Carol O'Hare, Executive Director for Nevada Council on Problem Gambling introduced herself and reported the following:

The Nevada Council on Problem Gambling is a non-profit information and referral agency whose mission is to generate awareness, promote education and advocate for quality treatment of problem gambling in the State of Nevada. Incorporated in 1984 by concerned members of the Las Vegas mental health and recovering community, and revitalized through it's first Corporate Membership program in 1995, the Council serves as a state-wide resource for information and services for individuals and families who are affected by problem gambling.

The Nevada Council is one of 33 state Affiliates of the National Council on Problem Gambling and as such, does not take a position for or against legalized gambling. Instead, our efforts are focused on addressing the issue of problem gambling as it affects individuals, families and communities within the State of Nevada. The Council is currently funded through fees for services and voluntary support from individuals and businesses through program sponsorships, in-kind donations and corporate membership contributions.

All of the programs of the Nevada Council on Problem Gambling have been developed and implemented through the cooperative support of a diverse group of individuals, organizations and businesses. The Council is governed by a volunteer Board of Directors and Advisors that contribute their time and expertise to guide policy and program development. Included on our Board are representatives from education, mental health, addictions, gaming companies, non-gaming companies, community service organizations and interested private citizens.

# PROGRAMS AND SERVICES

The term "problem gambling," for our purposes, refers to any gambling behavior that is damaging to the individual, the family, the workplace or the community. Within this definition, we are concerned for individuals with mild to moderate gambling problems, as well as those suffering the most severe problem known as pathological gambling, as defined by the American Psychiatric Association in their Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV).

In keeping with our mission, the Nevada Council has implemented a wide range of programs and services to address this issue in our state.

# Problem Gamblers HelpLine (1-800-522-4700)

Perhaps the most important service the Council provides to our state is the 24 hour Problem Gamblers HelpLine which provides the vital link between individuals experiencing gambling problems and the services available to meet their needs. Since 1997, the Nevada Council has provided this 24-hour, confidential service through our link to the National Council HelpLine system at 1-800-522-4700. Since 1999, all Nevada gaming operators are required to post this HelpLine number in gaming and cage areas, pursuant to Nevada Gaming Commission Regulation 5.170 – Programs to Address Problem Gambling.

The Problem Gamblers HelpLine utilizes an action-oriented, crisis intervention model and is staffed by trained specialists with expertise in both problem gambling and crisis intervention. The HelpLine specialists refer callers to appropriate resources in their geographic area, including treatment, support groups and ancillary community services to address their most immediate needs. In addition to these referrals, all callers are given the option to receive problem gambling information by mail.

In 2000, the Problem Gamblers HelpLine responded to a total of 2,877 calls for assistance. Of those, 1,436 of the callers were in need of direct help due to their or someone else's gambling problem. The remaining 1,441 calls were requests for general information about problem gambling and related programs and services.

From January to October of 2001, the Problem Gamblers HelpLine has responded to 1,073 requests for information and 1,134 requests for help for a year to date total of 2,207 calls.

## Public Awareness & Education

The Council engages in many activities to increase public awareness of problem gambling as a treatable disorder and to direct individuals to available treatment and support services. The Council utilizes various means to generate this awareness, including:

- Participation in print and broadcast media projects related to problem gambling
- Information and referral through the Council's website
- Participation in employee health fairs and other community wellness events
- Speakers Bureau presentations to community and social service agencies
- Presentations at gaming industry, mental health and other professional conferences
- Distribution of "When the Fun Stops" brochures to individuals, businesses and community agencies. (Total distribution since 1998 is over 955,000.)

In 1998, the Council developed a curriculum-based awareness program titled, "When the Fun Stops – Understanding Problem Gambling". Since that time the program has been used to train over 115,000 gaming employees throughout the state. The program has also been incorporated into the curriculum of the Hotel College at the University of Nevada – Las Vegas.

The Council is currently developing a 3-hour continuing education class for the Community College of Southern Nevada titled, "When There's a Gambling Problem in the Family". This class will be presented for the first time in the spring of 2002.

## Clinical Training and Professional Education

The Nevada Council facilitates clinical training that meets the education requirements established by the National Gambling Certification Board. Although no professional certification in gambling treatment is currently established in the State of Nevada, the Council encourages and recommends that treatment providers pursue the National Gambling Counselor Certification.

In 2000, the Council provided 30 hours of gambling specific training to more than 140 service providers in Nevada. Among those trained were 71 individuals from a variety of state agencies and state-funded programs and services, such as the Bureau of Alcohol and Drug Abuse, State of Nevada Division of Aging, and Southern Nevada Adult Mental Health.

Under the direction of Dr. Rena Nora, Chief of Psychiatry Services at the VA Medical Center in Las Vegas, the Council continues to develop ongoing training programs, conferences and seminars to provide problem gambling education to treatment providers and other professionals throughout Nevada. The Council also works collaboratively with other organizations that are interested in providing problem gambling related professional education. This past year's efforts include:

- "Addressing the Legal and Financial Impact of Problem Gambling" May 4, 2001 Co-sponsored by National Endowment for Financial Education and the UNLV International Gaming Institute
- "The Problem Gambling Client Intervention & Treatment Challenges" July 16 17, 2001 Summer Institute for Addiction and Prevention Studies
- "Problem Gambling the Hidden Addiction" Sept. 20, 2001 Presented to District Court Judges, sponsored by the Law Firm of Christensen & Sondgeroth
- "Toward Meaningful Diagnoses of Gambling Disorders" Dec. 2-4, 2001
   Co-sponsored by Harvard Medical School Division on Addictions and the National Center for Responsible Gaming

## <u>Underage Gambling Prevention</u>

The Nevada Council on Problem Gambling recognizes that our youth are also at risk. Many studies show significantly higher rates of problem gambling among youth than are found in the adult population. The Council continues to seek out opportunities to educate our youth and families about the risks and consequences of underage gambling. Some of these opportunities include:

• Inclusion of an underage gambling message in the Council's "When the Fun Stops" brochure

- Distribution of problem gambling information and resources to elementary and secondary school counselors in Clark County
- Inclusion of problem gambling brochures in new student orientation packets distributed at the University of Nevada-Las Vegas
- Recommendation of problem gambling questions to be included in Nevada's Safe and Drug Free Schools and Communities Survey to determine the level of gambling activity among Nevada youth
- Administration of the Project 21® Scholarship Program, in which Nevada high school and college students (under the age of 21) are awarded scholarship funds for their best efforts at raising awareness of the risks and consequences of underage gambling.

## Additional Efforts

The Nevada Council is involved in many other efforts on an ongoing basis that support our mission and the development of better resources to address problem gambling. While the Council does not directly provide treatment services, we do maintain a listing of gambling treatment providers throughout Nevada as part of our HelpLine Referral Directory. Inclusion in the directory is voluntary and is based on criteria established by the National Council on Problem Gambling for HelpLine referrals. In geographic areas where no gambling treatment providers are listed, a referral is made to other mental health providers in the area.

The Executive Director, Carol O'Hare, and other professionals who serve on the Board of Directors frequently participate in formal and informal discussions of problem gambling-related issues. In this manner the Council has served as an advocate and advisor on matters related to public policy, education, treatment, research and gaming regulation. We are also fortunate to have the support of a nationwide network of experts through our affiliation with the National Council on Problem Gambling. The sharing of information and resources made possible through this network is a great asset to our efforts on behalf of problem gamblers and their families in Nevada.

## SUMMARY

On behalf of the Nevada Council on Problem Gambling, Ms. O'Hare thanked the members of the Commission for the opportunity to provide them with this overview of the organization's programs and services. The Nevada Council is committed to serving as a central resource on problem gambling issues within our state and we will continue to make our organization available to participate in any forum that addresses this important concern.

Dr. Nora wished to reinforce that it made the biggest difference when casinos began dealing with the Council. A diagnosis for problem gambling was not established until 1980. This major health problem was not recognized until five years ago. 12 casinos/corporations gave The Nevada Council on Problem Gambling seed money for public awareness and research.

She further stated that mental health workers were not aware of the nuances for the most basic treatment of problem gambling. SNAMHS does require a one-day class to recognize

this. However, she noted there were not enough treatment programs available. We must be sure our mental health workers can absorb those needing help.

Dr. Richitt noted that the brochure stated that one should not let kids under 21 participate in any gambling activity.

Ms. O'Hare stated that the Council equated underage gambling to the days when we said it was okay to let the kids drink beer at home. Gambling problems have a 7% prevalence in youth compared to 1.7% in adults. An innovative approach is a new math curriculum, focusing on math, probability and statistics that introduces the concept of winning and learning. It is hoped that this will relate to kids later on.

Dr. Albers compared it to the tobacco industry putting money toward kids not smoking. He felt there was a responsibility at a higher level. Ms. O'Hare stated there were only two industries to follow – tobacco and/or alcohol. The templates were taken from the alcohol industry. They are following the model, however, it is far from completed.

Ms. O'Hare stated that a prevalence study would be ready after the end of the year. She further stressed that what was not available is treatment. She further reported there is a high incidence of dual diagnosis.

# MENTAL HEALTH PLANNING ADVISORY COUNCIL (MHPAC) REPORT

Mr. Andrew Zeiser referred the Commissioners to the CMHS 2001 implementation report. He stated that the format and content were driven by CMHS guidelines. During the oral defense of the FY 02-03 block grant, he happily reported that it went really well. It was the best grant review to date. It was the first year that Nevada has not been asked to make any modifications to the grant. Attending the grant review were Mr. Zeiser, Dr. Kevin Crowe, Mr. Jerry Clark and Ms. Alyce Thrash. He stated that each one contributed to answering important questions posed by the reviewers.

Ms. Thrash wanted to note that the agencies had some sort of link to first responders for emergency responders. There is currently a pilot program in the south to provide this awareness and training.

Dr. Crowe stated the review was a very positive one and that he was very proud of the MHPAC.

Dr. Brandenburg publicly acknowledged the hard work and the hundreds of hours contributed by Mr. Zeiser. He stated that the Commission sees only the end result. He also thanked the Council, Dr. Crowe and DCFS.

Mr. Zeiser responded to the Commission's request for inclusion of a letter of introduction from the Commission in MHPAC's possible printed resource brochure. Mr. Zeiser reported that the Nevada Recovery Guide was awarded a grant this past year and that we could request a link from their website. MHPAC will work with them to develop a print-based guide, which will be subgranted out. Ms. Thrash is drafting a letter of contract for the grant. We will ask to link our websites and to be involved in developing the resource guide.

Regarding the joint retreat with MHPAC and Commission members, Mr. Zeiser proposed February 6 and 7, the dates immediately preceding the next Commission meeting. He felt an informal gathering could take place the evening of 2/6, followed by an all day meeting on 2/7. He stated that Ms. Thrash would contact each of the Commissioners for their concerns and interests.

The Commissioners agreed to the February 6 and 7, 2002 joint meetings with MHPAC.

Dr. Crowe expressed his pleasure for the informal gathering of the two governing groups to help identify joint strategies for the legislature and budgets.

Ms. Rosetta Johnson expressed her thoughts that the retreat could help the Commission learn how MHPAC operated and how they could dovetail with one another. She mentioned she had mailed a survey to all Commissioners, but did not get a response from anyone but Ms. Brown. She stated that coordination of services was indicated on the survey. Mr. Ward stated that he had received the survey, but felt it was premature to list three priorities for the legislature at this early stage.

Ms. Johnson reported on an upcoming conference in 2002, perhaps in November or early December to address mental health across the lifeline. It will include discussion about mental health for children, adolescents and the elderly as well. She stated that Dr. Albers was part of that planning committee.

#### SUICIDE PREVENTION INTERIM STUDY COMMITTEE UPDATE

Ms. Linda Flatt, community organizer for Nevada's Suicide Prevention Advocacy Network (SPAN) introduced herself, stating that she was a survivor of her son Paul's suicide in 1993.

Ms. Flatt distributed statistics and a list of committee members. She stated that SCR 3 called for an interim study. The resolution itself lost, but the legislature appointed an interim study committee. Don Williams, LCB, is the chief coordinator. Please contact him for any input to the committee at 684-6867. She further discussed the November 9 meeting.

Dr. Brandenburg stated that the Commission received a complete copy of all materials that were distributed at the November 9 meeting.

Dr. Nora further stated that the materials were the best compilation of local resources.

## **CRISIS CALL CENTER SUICIDE HOTLINE**

Ms. Misty Allen reported the hotline was doing well. Their volume was up 200 calls from September, and she thought that would continue through the holidays. They now have two staff in the building at all times (24-hours per day). She stated the Crisis Center was battling with AT&T, their long distance carrier, regarding a new issue. She had a client on the phone that passed out; however, ATT would not give the address of the client and that call was disconnected.

Mr. Ward recommended this problem be brought to Senator Reid's attention. He felt the Senator could get a lot more action from AT&T.

**ACTION:** Dr. John Brailsford will send a list of Southern Nevada parishioners to Ms. Allen. Mr. Ward asked if the growth of 200 callers from September to October was non-Washoe County growth. Ms. Allen responded that the growth included both the north and the south, as well as basic needs calls.

Dr. Richitt noted an article in the paper; the paper had called and received no answer, or were disconnected. Ms. Allen state she was aware of that article. The most we can do is try to convey that information to the Southern Nevada center. There is free certification available through ASS. She said she did not know why Southern Nevada is not utilizing this. The north has safety nets behind its hotline. If Clark County could establish a safety net, it would be very helpful. The calls in Southern Nevada are not rolled over; they are given the phone number of the northern hotline. Ms. Allen stated she has talked to the director of the southern center, but was not taken very well.

**ACTION**: Ms. Allen will talk to the answering service in the south and see if a seamless rollover can be established.

Ms. Allen discussed her training appointment with Clark County.

Dr. Albers asked Ms. Allen to paint a picture of the apparent issues in the south. Ms. Allen stated that the southern center was a non-profit agency. But with free accreditation, they must have accountability; Board issues and agency issues must be addressed and remedied.

- Dr. Nora stated they were working on that issue.
- Dr. Albers stated that infrastructure was what was missing.
- Dr. Nora asked if the Commission would like to invite her to the next meeting.

**ACTION**: Add Dorothy Bryant to the next agenda. Dr. Nora will send the address to lke.

Dr. Albers asked that procedures be set up for after hours, so the Commission can be made aware of how this all works.

## **SNEA REPORT**

Ms. Janeen Lake, working on behalf of state employees for the state of Nevada introduced herself. She stated that SNEA has a new director, Mr. Scott Mackenzie, and he is focusing on employee issues rather than the grievance process. She reported general anxiety among state employees based on the fact that there is a hiring freeze; there is tremendous stress with increased workloads. State employees targeted for layoff is also a concern. There is a continuation of standard problems of morale issues and management/employees not communicating. We have established a number of work groups to head off grievances. MHDS has already established a work group. Issues are being resolved or being worked on; endeavoring to create a better process for management and employees. If employees feel they are being made a part of the process, the result is much better morale. We appreciate our state employees, and all their hard work.

Dr. Albers expressed his thanks for Ms. Lake's presentation. He stated that the Commission receives input from so many other sectors, that he was glad to hear from the line workers. He asked how many of the mental health technicians were members of SNEA. Ms. Lake responded that approximately 50% were members. The numbers are much higher in the south than the north. Mr. Mackenzie encourages open lines of communication. She stated he would be happy to bring in employees to speak to the Commission.

Mr. Ward stated that the Commission's intent was to reach out to state employees and let them know that the Commission is not the agency. We can be a resource for them, not necessarily in a Commission meeting, but we are available for contact.

Ms. Lake stated employees would appreciate that very much. She reported they had a large meeting in their office yesterday, and is excited about the direction these meetings are taking. She stated she would pass the Commission's message along to the members and encourage them to attend some of your meetings and comment on what is happening at their levels.

**ACTION**: Ms. Lake was asked to send agendas for each meeting to the Commission.

Dr. Brailsford asked if research or surveys were done. Ms. Lake said yes, referring to the recent survey done at MHDS not too long ago. Surveys are implemented because we don't want one group of employees saying this is the problem and another group saying there is another problem.

**ACTION:** Mr. Ward asked that SNEA share their data from the surveys with the Commission.

# UPDATE - PROFESSIONAL ASSOCIATION FOR ADVOCACY TO MEDICAID (SWs AND MFTs)

Mr. Stuart Gordon stated they had assembled representatives for Social Workers and Marriage and Family Therapists to dialog on the Medicaid issue. We have also been researching other states. We met two days ago with Mike Willden, Director, DHR and Mr. Chuck Duarte, Administrator, HCFAP to discuss this. Both sides will study the issues of the children on our waiting lists in Nevada. Mr. Gordon expressed his pleasure in this progress.

# MHDS ADVISORY BOARDS

# Southern Nevada

Ms. Santa Perez reported that the south was recruiting for two Board members, one consumer and one provider of services. She further reported that the DRC intake process was discussed in detail at their last meeting. We also discussed how mental health clients access the pharmacy. Board members would like clients to be able to fill their prescriptions at a pharmacy of their choosing. Mental health representatives will give a report on this issue at the next Board meeting. The Board is concerned about possible budget cuts due to the downturn in the economy and will be following this issue. It was decided to develop a brochure explaining the duties of the Board. This brochure can be used for recruitment of new members and for distribution throughout the community.

Mr. Stan Dodd reported that Ms. Perez was a long-term Board member, with a master's degree and she has a 6-month-old son.

Mr. Ward thanked Ms. Perez and asked that the brochures be shared with the Commission and the Northern Advisory Board.

**ACTION**: The Southern Nevada Advisory Board was asked to distribute copies of the brochure to the commission, as well as supply copies for the Northern Nevada Advisory Board.

## Northern Nevada

Mr. Stuart Gordon reported that the Northern Advisory Board met in November and stated that Dr. Albers attended. Issues discussed were increasing representation to the Board. We hope to include someone from disability resources to get some developmental services included. Ms. Maria Canfield, Chief, BADA, has been approached to become a member as well. The Board is hoping to expand to reach the populace and clients in Northern Nevada.

Mr. Ward commended Mr. Gordon and suggested they widen the spectrum of participation to the Board. He stated he looked forward to reviewing the resumes of candidates.

**ACTION**: Mr. Gordon was asked to get resumes to lke three weeks prior to the meeting so they could be included on the agenda and in the packets.

Dr. Albers stated that during the retreat with MHPAC, the Commission's relationship with the Advisory Boards should be included. He wondered if we couldn't include all four entities (MHPAC, Commission on MHDS, Northern Nevada Advisory Board and Southern Nevada Advisory Board). He noted that lack of continuity. He asked Mr. Gordon if he would be interested in being included in the retreat.

Mr. Gordon responded that he felt it was vital in order to keep all four entities on the same page.

Dr. Brailsford recommended we invite representatives from the Advisory Boards in the north and the south. Dr. Crowe stated he would try to bring that together.

**ACTION**: Dr. Crowe will let Mr. Zeiser know the Commission would like to include one representative each for the north and south Advisory Boards. Travel would only have to be paid for the Las Vegas member.

After discussion concerning the lack of travel funds for the Advisory Boards, Dr. Brandenburg reminded the Commission that before the Commission was established, the Governor eliminated the Advisory Boards. The Commission was supposed to be representing the local level. The Commissioners made the decision to continue the Boards.

Ms. Brown stated that the onus was on the Commissioners to get involved and carry the message.

#### **AGENCY DIRECTORS' REPORTS**

#### SNAMHS

Dr. Brandenburg reported that Dr. Jim Northrop has voluntarily stepped down as director of SNAMHS. We wish him well. Dr. Rosin is assuming those responsibilities until a replacement can be found.

Dr. Brandenburg stated that Dr. Northrop suffered a heart attack three weeks ago. This is his second heart attack. The first one occurred during budget development. Dr. Northrop's physician advised that he must reduce his stress level. Very reluctantly, Dr. Northrop asked if he could step down and whether or not we could find him a position in the system. With Ms. Cindy Pyzel's help, Dr. Northrop will now be a psychologist in inpatient at SNAMHS on a ½-time basis. Dr. Northrop has been very instrumental in networking in the community. We have decided that on a temporary basis, Dr. Rosin will be acting director and we will launch a recruitment effort. Dr. Brandenburg stated that Dr. Northrop's were big shoes to fill.

Dr. Richitt asked that MHDS move in all deliberate speed to fill the position.

Dr. Rosin stated SNAMHS has been operating with a management team. He reported a deficit in personnel with no director of medical records. SNAMHS is finalizing the search for an ASO; the final interview is scheduled this week. The management team will then be intact at the senior level.

He further reported a crisis in physicians. When a physician is ill, we do not have a physician at our clinical site. This is critical due to the flu season. We are operating W. Charleston with  $\frac{1}{2}$  doctor per day. DI operates with  $\frac{3}{4}$  doctor per day. In terms of recruitment, one doctor experienced acute renal failure due to medications and might return this spring. Another doctor had difficulty with the medical board. One physician will start in January. One will come on board in July. We have found two locums with Nevada licenses and/or are qualified for temporary Nevada license. We are in conflict with state licensing board at this time; we're trying to have them squeeze in our two issues on the upcoming agenda as well. Our numbers run from 10 - 11 to 23 of those sitting in ERs. We are developing statistics that will be presented Monday to Dr. Brandenburg to see if our UMC doctors are worthwhile.

Dr. Albers stated that it did sound like a crisis. Dr. Rosin stated they had been in crisis since September, we are burning out our physicians. It is an ongoing crisis, however, we continue to spend money in advertising and the interview process.

Ms. Brown stated that workloads are alarming regarding stress related issues.

Dr. Rosin stated that SNAMHS was down three nurses in the clinics. Outpatient services are severely handicapped. Long term effects is that we recreate issues of bringing people into the hospital due to failure of care.

Dr. Brailsford noted similar staffing issues in DCFS and RC. There are a high percentage of vacancies there, and they are struggling with the same issues. If the legislature will fund 25 positions for \$35,000, he felt it would be much better to fund 10 positions at \$50,000.

Dr. Brandenburg stated that MHDS is very competitive in salary range for psychiatrists. However, nationally, there is a shortage of psychiatrists. Even though we are competitive, there is a pool shortage.

Ms. Brown stated that there was a major crisis in many health positions.

Dr. Brandenburg stated that the metropolitan areas draw more applicants than our rural areas. Arizona rurals and rural Wyoming have an incentive package available to pay for graduate school.

Dr. Albers stated that he thought DCFS was paying student stipends in exchange for one year of work.

Mr. Ray Kendall stated that RC was paying moving expenses to rural areas. There is a lifestyle in rurals where you are visible all the time. You are on call 50% of the time. It takes a very special person to find that appealing.

Dr. Brandenburg stated it affects MHDS and DCFS because of the financial position the state is in. If our budgets are cut, the first thing to go away will be the vacant positions.

Dr. Albers stated it was deja vu from 1992.

Dr. Brandenburg stated that the Department Director offered that. I don't think that will be the case this time, but we will have to step up to the plate.

Dr. Albers stated that as our economy sickens, so does our society. He expressed his alarm at the burnout of our physicians, and stated that the issue was catastrophic.

Dr. Brandenburg stated that we are there and we live that day in and day out. If you can offer a nice solution, please let us know. It is a crisis, but to Dr. Rosin's credit, we have not yet closed one clinic in Southern Nevada. If we go down with the ship, we will go down serving our clients.

Dr. Richitt reported to Dr. Rosin that there is a Southern Nevada group of psychiatrists, and asked if there was a northern group. She thought it might be worthwhile in recruiting them. Dr. Rosin stated that in the south, they were contracting for hours. One psychiatrist wants to volunteer without pay. It helps but does not fill the gap. We schedule regular meetings to assess our crisis and we may condense our services to prevent burnout, but not the need for treatment. We are crisis managing at this time.

Dr. Albers asked if crisis management meant giving up the algorithm. Dr. Rosin said no, it continues on a trial basis in both the north and south. We conduct regularly scheduled follow-up, based on experience, and we plan to institute it with our new clients north and south. We have received our training tapes from Texas and will begin training.

## DCFS

Ms. Patty Merrifield, DCFS-South Program Manager for Community-based Health introduced Ms. Diane Jungwirth, Deputy Administrator for DCFS. She further reported that Mr. Edward Cotton would begin 12/17/01 as the Administrator. He is coming to us from Illinois with 27 years experience in the child welfare system. Ms. Merrifield reported that AB1 child welfare integration law has a significant portion regarding mental health. We are progressing; a meeting has been scheduled in the northern region for 12/10/01. We are also targeting a meeting in the south for the consortium during the 2<sup>nd</sup> week in January. As part of the effort in the south, we have formed a community advisory committee. A decision was made to ask the

same individuals from the Mental Health Consortium and the County to participate. The same members will meet once and divide the agenda so they can focus on the child mental health issues.

Dr. Fricke stated that children who are homicidal or suicidal are placed at UMC on the psychiatric ward. She felt this was inappropriate and asked how to address it. Ms. Merrifield stated that Spring Mountain Treatment Center is not full and asked Dr. Fricke to speak with Dr. Christa Peterson directly.

**ACTION**: Ike was asked to email Christa Peterson's address and phone number to Dr. Fricke.

Ms. Merrifield reported that regarding the hiring freeze; DCFS has 42 vacancies in our mental health programs. The impact is that fewer are being served. We are at the point with our outpatient services that we are triaging those that need to be served right now, all others must wait. We are facing the same fiscal problems as MHDS.

Dr. Albers asked if we were just going to sit on this. This is a crisis. We must do something!

### **PUBLIC COMMENT**

Nothing to report.

#### **INFORMATIONAL**

Dr. Brandenburg stated that he was fortunate enough to go to a conference in New York regarding terrorism and its effects on our mental health service system. Nevada citizens are calling regarding bio-terrorism. The Public Health Department has asked MHDS to assist them. He reported that the Commissioner's packets contained publications that he received at the New York conference.

## PERFORMANCE INDICATOR UPDATE

Kevin Crowe stated that the quarterly report would be completed soon. He is working with the advocacy groups to report performance measures. Indicators reflect on keeping people out of the hospital. We measure clients who are in the hospital for more than 90 days. Most of our clients are in multiple programs. We have broken out the data to break out the programs.

Dr. Albers asked what baseline we were starting from. Dr. Crowe reported that this would be our baseline. Dr. Albers asked if we could make a presumption that, due to vacancies, our performance will decrease. Dr. Brandenburg stated that the rurals will show indications that clients will be waiting longer than 90 days. He reported that this gives us ammunition for presentation to the legislature. When MHDS was talking with Mr. Perry Comeaux, we used this to argue effectively to try to recruit for these positions.

Mr. Ward noted the PACT Performance Indicators. He asked that if you had a 45-year-old patient who has an opening to PACT, does he have 45 years of potential inpatient days. Dr. Crowe stated that the data would go back to the previous quarter each time.

Dr. Brandenburg stated that even before they get accepted into PACT, we are asking them to go back and choose those individuals who had a high readmission rate into the hospital. That

is the one variable before they get accepted into PACT. We also review the number of days in the community.

Dr. Crowe reported and expressed his pleasure that the monthly reports and quarterly reports would be available on MHDS' website.

**ACTION**: The Commission asked for a similar report from DCFS regarding Performance Indicators for the next meeting.

#### SNAMHS POLICY REGARDING MEDICAL SCREENING

Dr. Albers reported that he was contacted by the State Licensing Board for Social Workers concerning the issue that arose regarding social workers being requested to do medical screenings. The Board received forms indicating what they were being requested to do regarding medical screenings. If they are acting out of the scope of their profession, they will be held liable, especially if a death occurs. Dr. Albers stated the Board was interested in the SNAMHS process and whether they were aware of social workers' scope of work.

Dr. Richitt noted several indicators found in the form; vital signs, temperature, blood pressure, etc. She felt this was very much outside their scope of work.

Dr. Rosin stated that approximately 1-1/2 months ago, SNAMHS had a visit by federal HICFA, investigating our ability to do emergency medical screening in our walk-in emergency area. We were the second hospital to have this site visit. This is a national push by federal HICFA throughout the country requiring freestanding psychiatric hospitals to be in compliance with EMTALA laws (to evade patient dumping). We were given a very brief amount time to fix this. Our plan has been HICFA approved, we did have psychologists and social workers asking about taking histories. The QMP (qualified medical personnel) are trained to take histories and to ask questions. They are not asked to diagnose, only to report. The form is not designed to take a full medical history, it is to determine if transfer to another Emergency Room is indicated.

Dr. Albers stated that QMPs should not be doing this type of work. How are they qualified? Dr. Rosin stated that in the north, technicians are already trained to do vitals with electronic devices. Operationally, we do have access to a nurse and physician.

Ms. Chelsea Szklany, Program Improvement staff member at SNAMHS, Roxanne Callo, Director of PAS, and Vicki Slater of POU introduced themselves and stated that SNAMHS had to come into compliance by November 20 or lose federal funding. We looked at standards of care in other PES. In developing medical screening, SNAMHS requires all clinical staff to train in safety training. Our clinicians are already trained by medical standards and they must maintain these standards. For each of these services, we have a training program, renewing every year or every two years. It is competency based. QMPs solicit a response, but do not pass judgement. Acute mental health clients do not always document properly if asked to complete a questionnaire by themselves.

Dr. Albers asked if Ms. Szklany had personally contacted the Board. Ms. Szklany replied no, but that she strongly believed and stated that, in a very diplomatic way, change is hard but this

had to be implemented very quickly. She further stated she believed it was the Board's responsibility to investigate. We may be asking for too much information.

Dr. Rosin stated that in the classical review of systems, under endocrine problems, there is a list of questions we ask. Dr. Albers stated he still felt that SWs were acting out of their scope of work.

Dr. Brandenburg stated that this couldn't be resolved today. When the federal government came, we were under a time crunch. There seems to be a difference of opinion between our legal counsel and the Board. He suggested a meeting to see what could be resolved. There is some logistics problems involved. We may need to reclass those positions.

Dr. Albers stated that his suspicion was that the social workers were setting themselves up for losing their licensing.

Dr. Rosin stated that they are talking about EMTALA issues, dealing with immediate medical problems. We are in the process of simplifying the form in terms of listing just the questions that need to be asked and determining what constitutes a medical emergency.

**ACTION**: Dr. Brandenburg asked that a meeting be set up for Drs. Albers and Rosin, as well as SNAMHS staff to discuss this issue. They will report to the MFTs and Psychologists as well. He asked for an update at the next Commission meeting.

**ACTION**: Dr. Albers asked that Dr. Rosin let the SNAMHS' social workers know this item was brought up to the Commission for discussion and that meetings will be forthcoming. He stated that for the record, this issue came from the SW Licensing Board.

Ms. Szklany stated that they do have nurses on site 24-hours per day. We do have that capacity covered.

Dr. Rosin stated that to get the HICFA fix, we had to change the bylaws, training and follow-up. The Governing Board of SNAMHS did approved this. The Attorney General did consult with the Medical Examiners Board.

## HCFAP GRANT MONEY REGARDING VIDEO CONFERENCING

Dr. Crowe stated he did a follow-up with the folks at Medicaid. They have a very low-end system, and he felt it would be a very negative experience for the Commissioners. It had poor sound quality, and had no ability to take minutes. He felt this route was a dead end.

## **COMMISSIONERS 2-YEAR GOALS/ROUNDTABLE**

Crisis situation regarding staffing shortages.

Mr. Ward noted that MHDS had obtained permission to hire part-time Nurse Practitioners and, therefore, may have to give up a psychiatric position. Dr. Rosin stated that for every psychiatric position we give up, we would be able fund two Nurse Practitioners. We do have Nurse Practitioners that have expressed an interest.

Dr. Richitt stated it must be termed as a crisis and temporary.

Dr. Albers asked if MHDS would lose their psychiatric positions. Dr. Brandenburg stated that MHDS would not let Dr. Rosin lose those psychiatric positions.

Ms. Brown stated that APNs have the ability to get additional certification.

Dr. Albers asked if there was a potential power differential. Dr. Brandenburg stated that in the beginning, it was the case at NNAMHS, but when the doctors realized how helpful it was, they came to appreciate the Nurse Practitioner.

Dr. Nora stated that they have used Nurse Practitioners for very long time at the VA, and found them to be more meticulous in reporting and conducting physical exams.

Dr. Richitt noted the needs/concerns from the agency directors' reports. The hiring freeze and the fiscal situation in the state may cause reductions in staff throughout state. Is there something more proactive we can do to alleviate that?

Dr. Brailsford recommended coordination and consolidation of services. If no one can effectively staff a facility, maybe we can utilize all entities. The strategic plan will be helpful in this area.

Dr. Brandenburg stated even though there is a hiring freeze, the Governor is approving those positions that are termed "life safety" for both DCFS and MHDS. We have received a list from the budget office, and 14 or 15 positions have been approved. It was more difficult to fill our ASO at SNAMHS, however we did get that approved, On both the mental health and the developmental services side, both inpatient and outpatient, we are getting a great deal of support from our executive branch.

Mr. Ward asked the Commission to look at the big picture. Two years ago last January, he and two other Commission members met with the Governor. At first glance, there was not enough money to go around the state. He thought we should take a look at taxation. We need a base income for the state. In the interim, for the 3<sup>rd</sup> session in a row, MHDS and DCFS experienced substantial increases (which were much needed). The Governor has created a panel from which those funds come. The long-term picture seems optimistic. The Commission must make sure there is a continuing flow of information to the Governor from a wide variety of entities regarding needed funding.

Mr. Ward further stated that with regards to the Commission's planning meeting held on 11/1/01, we don't want to lose sight of what we discussed. What is needed to make the Commission more effective.? We would like to see each Commissioner take on assignments voluntarily to bring back feedback from employees and clients to the Commission. We must report to one another about meetings from NAMI, etc. I will be meeting on Monday with a woman (parent of a client at SRC). Dr. Albers and I met with her previously, along with Dr. David Luke and Ms. Debbie Hosselkus. Dr. Brandenburg and Dr. Luke will meet with her first hand.

Ms. Brown stated that the Commissioners must complete the visits to all the agencies. She felt the Commission should collaborate with other state agencies to develop a comprehensive

state plan. She also stressed the importance of supporting the statewide plan for suicide prevention.

Dr. Nora asked if there was a mental health response team. Dr. Rosin stated that SNAMHS just completed training from Red Cross.

Dr. Crowe noted that Clark County Emergency Rooms, Clark County Social Services and Clark County Red Cross are ready to participate in any emergency.

Dr. Brandenburg stated that the State Disaster Plan was coming together. He reported he had recently gone to New York to deal with just this issue., specifically in regard to public health response to terrorism. It is now a high profile item.

**ACTION**: Emergency Plan for three regions will be presented at next meeting by Dr. Crowe.

Dr. Brailsford indicated his priorities were the 5-year plan, coordination of services, suicide, cooccurring disorders (HIV/AIDS, gambling, cancer, substance abuse, etc. involving behaviors that put them at higher risk), child and adolescent issues regarding violence to self and others (he felt these clients were dropping through the cracks).

Dr. Brailsford also asked if the Commission would commend Dr. Northrop for a job well done.

Dr. Fricke mentioned the increased number of children with autism. Parents are trying to get coordinated efforts and services and are trying to deal with things that should be dealt with by professionals.

Dr. Brandenburg stated that AB 513 dealt with DHR's strategic plan. The Governor funded \$800,000 to address a strategic plan for the disabled population. He informed Dr. Fricke that AB 513 had a specific section that deals with autism. He asked Dr. Fricke to give him a call so he could connect her with the chair of that committee.

Dr. Albers stated it was nice to see the Commission reach their sense of identity. He welcomed Dr. Fricke. In terms of coordination, in spite of the Commission attacking it, I see what MHDS is doing with DCFS and Health. It is happening almost naturally and I encourage that. I am, however, concerned about staff morale. This will create a poor climate in which the clients will suffer. Also, I'm glad to see DCFS stay throughout the entire meeting. Dr. Albers thanked Dr. Crowe for the statistics; he felt they made very good sense for the Commissioners.

**ACTION**: The DAG was asked to send letter to hospitals to request their policies and procedures for restraint and seclusion, as well as denials. The DAG was asked to include Valley Hospital as well.

Dr. Albers stated that during the NNAMHS governing board meeting, there were several issues brought up concerning outpatient services and stress.

**ACTION**: The Commission is reminded to get their annual report to the Governor, as it is due the 1<sup>st</sup> part of each year.

**ACTION:** The Commissioners reassigned the review of seclusion and restraints and denials. They also reassigned subcommittee members:

## DENIAL OF RIGHTS AND SECLUSION/RESTRAINTS REVIEW

Mr. David Ward - RRC, SRC

Dr. John Brailsford – NNAMHS

Ms. Fran Brown - LCC

Dr. Eric Albers - West Hills and Rural Clinics

Dr. Rena Nora – Montevista and Lake Mead Valley Hospital, Geriatric Site

Dr. Elizabeth Richitt - SNAMHS and DRC

Dr. Johanna Fricke – Desert Willow & Willow Springs

## SUBCOMMITTEE ROSTER

Legislative Subcommittee David Ward, Chair

Eric Albers
John Brailsford

Clinical Subcommittee Fran Brown

Eric Albers

John Brailsford, Chair

Rena Nora

Consumer Subcommittee Johanna Fricke, Chair

David Ward Elizabeth Richitt

**MOTION:** Dr. Albers made a motion to adjourn. Mr. Ward seconded. Motion carried.

Respectfully submitted,

Ike Cress

Recording Secretary